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ABSTRACT

Previous research in suicidology has revealed that Caucasian males in their 80's pose the greatest suicide risk of any segment of the population. Only a few people have begun to investigate the interrelationships of this target population with the particular environments in which they reside. Realizing that the median age of Skilled Nursing Facility (SNF) patients is roughly 84, it appears logical that there is a significant suicide risk among Caucasian males residing in this environment. Pertinent questions were asked those people (nurses' aides and orderlies) who are the primary caregivers to this target population about the subtle nuances of geriatric suicidal behaviors. The primary hypothesis is that these caregivers are not attuned to the "subintentional" suicide tendencies their patients could very well be exhibiting (as conventional methods of suicide are unlikely to be exhibited in this environment). The dependent variable is the feeling of helplessness that caregivers might exhibit if they are unable to intervene on behalf of the self-destructive patient because of inadequate knowledge of this suicidological typology. The SNF Staff Suicide Awareness Scale is designed to ask these questions and test these hypotheses. (Author/BMW)

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THE SKILLED NURSING FACILITY STAFF SUICIDE AWARENESS SCALE (S.A.S.)

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THE SKILLED NURSING FACILITY STAFF SUICIDE AWARENESS SCALE (S.A.S.)

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INTRODUCTION

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INTRODUCTION

Background on Geriatric Suicidology

While suicide ranks as one of the top ten causes of death in America, the group of people most likely to take their own lives are white males over the age of eighty. Should this high frequency be so surprising, considering that old age for some is a time of emptiness, disengagement, physical ailments and downward occupational mobility? According to Kastenbaum and Candy in 1974, every American has at least a 25% chance of spending some part of his life in a nursing home; however, only 5% of American elderly reside in institutions at any one time. Since most suicides are committed by white males in their eighties who have a 25% chance of being in nursing homes and since the median age of nursing home residents is around 84, the author of this paper is interested in exploring an interesting issue: how informed are nursing home personnel in the area of suicide prevention and intervention seeing that most of their male patients are a high suicide risk? While the answer to this question will be presented later in this paper, this section will present pertinent background information, literary research and analysis of the scope of the problem of suicide among institutionalized elderly in America.

One of the pioneer studies of suicide in America was published in 1951 by Emile Durkheim. While Durkheim made no distinction between the likelihood of an elderly person committing suicide and the likelihood of an elderly person committing suicide in an institution, he does establish sub-types of suicidal behavior which might provide clues for detecting suicidal tendencies in institutionalized elderly patients. The application of the knowledge of these sub-types will be made on page 4, following a brief presentation of Durkheim's theories of suicide.

Emile Durkheim's General Theories of Suicide

Emile Durkheim's theories of suicides are not formulae for determining who will and will not commit suicide; rather, he proposes a number of hypotheses about suicidal tendencies among individuals on both a micro and macro level. Among his first level-generalizations, Durkheim noted the following: that city dwellers are more likely to commit suicide than rural dwellers, older adults more than younger adults, majority groups more than minority groups, Protestants more than Catholics, [Catholics] more than Jews, males more than females and unmarried more than married (Durkheim, 1951). Using these first-level generalizations as bases, Durkheim takes a more macro view of suicide as evidenced in his second-level generalization: *"Suicide varies inversely with the degree of integration of religious, domestic and political societies"* (*Ibid.*). On a third level, Durkheim posits a broad hypothesis of general suicidal tendencies:

"Suicide varies inversely with the degree of integration of the social groups of which the individual forms a part" (*Ibid.*). These generalizations will be recalled in various parts of the body of this introduction.

Durkheim, in Book Two of Suicide, discusses four sociological categories of suicidal people. The four categories are egoistic, altruistic, anomic and fatalistic. Of them, egoistic, anomic and fatalistic are categories most apropos to this study of the concerns of the institutionalized elderly. Among the present cohort of elderly in America, few were raised with a value system that preached suicide as an obligation, referred to as altruistic suicide; hence, it is conceivable that few elderly in the present cohort commit altruistic suicide.

Egoistic suicide is defined as the result of a lack of social integration characterized by an apathetic attitude towards life. The two subtypes of egoistic suicide posited by Durkheim are "melancholic languor"--characterized by depression and inactivity--and "epicureanism" where the apathy is manifested as a "disillusioned matter-of-factness" (Maris, 1969). In egoistic suicide, generally speaking, society influences the act of suicide by virtue of its constraints upon its members.

Anomic suicide is the result of changed societal norms; Durkheim suggests that "any disturbances in the collective order can lead to an increased suicide rate" (Durkheim, 1951). When one's personal equilibrium cannot adjust to compensate for new societal expectations, confusion and disorientation could logically result. Anomic suicides are generally violdnt; suicides of this type usually employ violence against a person or society to justify the persons' deaths. (An example of violence against society could be mass murders culminating in suicide.)

Fatalistic suicide is a result of excessive regulation which is common among slaves and prisoners. While anomic suicide is the result of deregulation and normlessness, fatalistic suicide is a response to hyperregulation. With respect to hyperregulation, suicide becomes an escape from unbearable restrictions. Fatalistic suicide is mentioned by Durkheim only in a footnote; as a result, many suicidologists--people who study the processes of suicide--feel that fatalistic suicide is not a *bona fide* category of suicidal tendencies.

Applications of Durkheim's Sub-Types to the Nursing Home Environment

While nursing home residents are not slaves, some sociologists describe these patients as prisoners; those patients who indeed see themselves as prisoners and seek to escape the plethora of nursing home regulations do so by committing *fatalistic* suicide. Nursing homes typically offer lower levels of stimulation to their patients and are a source of fear to newly relocated patients. While any new environment is a source of fear to most people, an abrupt change to a radically different environment is of especial fear to the frail elderly. While newly admitted elderly from community residences are the most affected by the low levels of stimulation that nursing homes evoke, admissions from acute care facilities are almost as vulnerable. (It should be noted that under current Medicare regulations, a patient admitted to a nursing home--otherwise known as a Skilled Nursing Facility--must spend three full days in an acute hospital prior to relocation; consequently, research studying the phenomena of morbidity and mortality following relocation to a Skilled Nursing Facility do not always take into account the relative abruptness of the relocation and the relative difference of the nursing home environment as compared to community and acute hospital residences. Failure to take these variables into account may explain the huge variances that exist among different research projects that study the relocation phenomenon.) While the initial response by newly admitted patients is that the facility allows them no individuality, the longer process of institutionalization destroys the patient's will to act as an individual. New patients, still suffering from the shock of relocation, who commit suicide do so out of confusion over the new norms thrust upon them by the nursing home environment; this type of suicide would be classified by Durkheim as anomic. There has been speculation that the low levels of stimulation in combination with the effects of medications and isolation from family and friends create a propinquity toward egoistic suicide, particularly of the sub-type "melancholic languor."

Description of the Nursing Home Environment

Nursing homes are licensed by each state to provide twenty-four hour nursing [medical] care. They conform to the same regulations as acute care facilities, yet receive income that is one-tenth of that collected by any hospital. Much of a nursing home's budget is spent to provide quality medical care; only a pittance is spent on providing quality psycho-social care. Regulations require a nursing home to employ an Activities Director if the facility is in California, and to devote a large enough space to accomodate a sizeable number of patients in wheelchairs. In reality, the Activity Director is licensed after

completing three required classes offered at a junior college; a graduate of this program knows very little about gerontology, the psycho-social needs of the older institutionalized patient or appropriate interventions that could be made to make life more meaningful for nursing home patients. In nursing homes, patients are perceived as of a lower echelon than staff; at home, children who care for their elderly parents have always been subordinate in status to the "patient."

Environmental Implications for Geriatric Suicides

In some people's view, a nursing home can operate efficiently only if all of its patients are stripped of their individuality. Institutionalization, nevertheless, is a common phenomenon in nursing homes; it is the process by which independent activities are eventually forbidden to the individual and reassigned to others. When institutionalization occurs, the facility then decides when a patient will sleep and wakeup, eat and drink, urinate and defecate, smoke, talk, sing, have sex, walk and even think. While suicide is an answer to these losses that the patient faces, the method is vastly different by virtue of the constraints that the nursing home places on the individual. Since the patient has no access to weapons, no privacy nor right of egress from the facility, the ability of the patient to perform violent acts of suicide is severely restricted. Even more passive means of suicide, like drug overdose, is impossible, for the nursing staff is very efficient at keeping the medicine-room off limits for patients and non-licensed staff. For a nursing home patient to commit suicide, he/she must resort to very subtle methods drawn out over time to reduce suspicion by the staff and other patients.

Indirect attempts at suicide are often so subtle that nursing home staff members seldom view such actions as suicidal. It is much safer for an aide to attribute a patient's refusal of meals or medicines as a function of confusion or hostility. Social workers, if they are employed by the facility, are rarely notified of these seemingly trivial behaviors (even over extended periods of time). In a lecture delivered in 1974 at the University of Southern California, Dr. Caleb Finch coined the term "benign suicide" to describe attempts at indirect self-destruction (Finch, 1974). In their book, Aging and Mental Health, Dr. Robert Butler and Myrna Lewis refer to the process of "subintentional" suicide which is accomplished by stretching the time period of suicide and making individual actions less obvious. Butler and Lewis note that processes of long-term suicide usually go unnoticed and are not considered when calculating sui-

cide statistics, for suicide is usually seen as a single act involving a quick trajectory toward death.

Among institutionalized elderly, Butler and Lewis view suicide as a result of depression. Depressive reactions are not uncommon in advanced stages of Parkinson's disease and are commonly associated with lucid moments of the patient with chronic brain syndrome (Butler and Lewis, 1977). Depression is commonly observed in connection with the lowered self-esteem a patient faces due to reduced social and paerosnal valuation and status. Depression is common among the elderly in general, for they are subject to increased numbers of personal and physical losses. Since nursing home patients face additional lossed of independence and psycho-social supports in addition to the losses they experience with their elderly status, the increased depression they face may be the motivating factor to commit suicide.

Subintentional Suicidological Biases

There exist a couple of biases when discussing suicide, especially among institutionalized elderly. One bias is the underreporting of suicides. In a recent article in The Gerontologist, Dr. Marv Miller notes the following:

> "A realistic estimate of the scope of this phenomenon [underreporting] is that the number of suicides erroneously certified as accidents or natural deaths in the United States each year is probably at least as great as the number of reported suicides. It is also likely that the underreporting of suicidal deaths occurs even more frequently among the elderly than other age groups because the certification of an older person's death due to natural causes would not normally arouse much curiosity" (Miller, 1978).

Another reason for underreporting is due to deception by the families to protect life insurance benefits, since many policies include clauses that negate benefits when death is voluntarily caused by the insured. Still another reason involves shame and guilt, especially among religious survivors; Orthodox Judaism goes so far as to deny burial rites to victims of suicide.

A second bias to be considered is the question of whether intervention is always appropriate. Legally, intervention must be made if the person is a genuine threat to himself or others. However, why intervention is permissable in any circumstance is not answered by any law. Suicide is, after all, a decision; Breed seems to feel that suicide among the elderly is a rational decision (Breed, 1963). Breed also notes, "that male suicides appear to be more closely related to retirement, unemployment, and downward occupational mobility, all of which tend to occur relatively late in life" (Ibid., 1963). Among the elderly, suicide is not a "cry for help" that could be provided as at earlier ages, through intervention. Elderly people contemplating suicide need special interventions, such as will be discussed later in this introduction.

Implications of Subintentional Suicide for Facilities

Suicide among institutionalized elderly presents problems to the facility. These problems would not be relevant to a person still in the community independently.

With respect to suicide among its patients, a nursing home has at least three alternatives, two of which will be presented here: 1) treat all suicides as accidents or natural deaths or 2) treat apparent suicides as suicides and face unfavorable media coverage and possible governmental intervention. The latter alternative is not at all absurd; the media would love the opportunity to causally link poor patient care in nursing homes with suicide. Such reactions by society to suicide among institutionalized elderly would have an inverse effect on new admissions to the particular nursing home; the result would be poorer patient care and increased costs that would be passed on to the consumer. For obvious reasons, most nursing homes either are not attuned to the incidence of suicide among their patients or are attunde but refuse to label such deaths as suicides. The result of this decision would be an increased incidence of underreporting of suicides which is the reason that no statistics for suicide among institutionalized elderly exist; the only assumption that could be made is that the number of unreported suicides in institutions is probably very high among white males.

A third alternative for nursing homes is to make a concerted effort to reduce the incidence of suicide among the patients. In order to reduce suicide, two separate actions must be undertaken: correctly detect suicidal tendencies among patients and make appropriate interventions particular to the

needs of the patients. A presentation of subintentional suicidal tendencies will be made followed by a discussion of staff and patient needs relevant to appropriate interventions.

Considerations and Methods of Detecting Subintentional Suicidal Tendencies

One of the most important considerations in detecting suicidal tendencies among institutionalized elderly patients is to rule out those behaviors that may be organic rather than psychogenic. In their study, Robert Kastenbaum and Brian Mishara listed thirteen behaviors that appear to be psychogenic but are actually organic.

> "1. Injury due to the inability to walk adequately, falling down.
> 2. Bumping into objects such as the wall.
> 3. Climbing out of wheelchairs and falling.
> 4. Scratching self.
> 5. Undressing self [in public].
> 6. Injury due to careless use of cigarettes.
> 7. Scalding hands by turning on hot water.
> 8. Choking due to eating too fast.
> 9. Eating foreign objects.
> 10. Fighting, pushing, etc.
> 11. Tripping over one another and being injured.
> 12. Striking the wall or window.
> 13. Injury due to hostility evoked by stealing another's cigarettes" (Kastenbaum and Mishara, 1971).

While all thirteen behaviors observed in this study may have been observed among patients whom have already been classified as suicidal, they are not alone indicative of suicidal tendencies. Kastenbaum and Mishara identify four "life-threatening maneuvers" (Burnside, 1976) frequently carried out by elderly institutionalized patients: refusing medications, failing to follow the orders of physicians, refusing to eat or accept food and situating oneself in hazardous environments.

Refusing medications is not hard for a patient bent on committing subintentional suicide. Frequently, medications are dispensed by registered or licensed vocational nurses who do not want to be bothered by stubborn or cantankerous patients. After coaxing and bribery fails in enticing a stubborn or violent patient to take his/her medicines, the nurse will usually give up trying and simply chart that the patient was uncooperative and should be medicated on the next shift. More often than not, the process of procrastination could conceivably allow patients to go unmedicated indefinitely. Unless the facility has a surplus of aides and orderlies to help licensed nurses administer medications, stubbornness in taking medications (even with the intent to

commit suicide as a result) is positively reinforced in skilled nursing facilities.

It is very rare for a patient who *fails to follow the orders of the attending physician* to be chastized or confronted; instead, the patient's actions and motives are frequently ignored. On the other hand, it is not unusual to find a patient with a history of emphysema or angina persuading staff to allow him/her to smoke. The response by the staff to a patient disobeying the doctor's orders in such instances may be so severe that the problem is exacerbated; some of the punishments that the staff administer may make the patient even more resistant to "treatment" (and thus negatively reinforce the patient's original intent to disobey the doctor's orders). Staff abuse of patients suffering from chronic brain syndrome is especially common, and secondary to staff abuse of those suffering from alcoholism. For these and other reasons, patients with past histories of alcoholism are very high suicidal risks in nursing homes.

A patient that *refuses food* is usually detected by the staff within a short period of time, especially if the patient was known to be a "big eater." For the first few times, poor intake will simply be charted and a memorandum to that effect will be filed in the nurse's notes. After a while, some facilities will require patients who refuse to eat to be force fed with a gavage; while the patient may be forced into eating, he/she is never forced into *accepting food.* It is very easy for a patient to go into the bathroom and induce vomiting. Generally, refusing to eat or ingest food is more a psychopathological problem (such as anorexia nervosa) than a mere exercise in stubbornness among suicidal elderly. If staff understood this emotional need, instead of simply attending to the physical disturbances associated with the need, the staff could provide better patient care and minimize the harmful effects of suicide previously discussed.

Placing oneself in a hazardous situation is a life-threatening maneuver rarely detected in a nursing home. Too many times, an aide or orderly is blamed for leaving in a hazardous situation with the admonition that the patient is "senile" and can't think for him/herself. With such an approach, a patient is never seen as putting him/herself in a hazardous situation as an act of subintentional suicide, but one of neglect by the nursing staff. It is not surprising that "accidents" resulting from a patient being left outside in the cold without a sweater or jacket on (in this case, accidental hypothermia is the resulting condition), from a patient being left by a radiator or by a drafty window are also viewed as the fault of the staff, but never the patient.

Supportive Techniques for Dealing With Subintentionally Suicidal Patients

Irene Burnside recommends three major considerations that helping professionals in nursing homes must utilize in dealing with suicidal persons. Separate from these, a fourth recommendation is made dealing with the honesty and sincerity that helping professionals need in order to deal with their elderly suicidal patients. Following are the considerations to be made for subintentionally suicidal patients:

1. *Establishing a "Protective Environment."* The only reason a person would commit suicide subintentionally is because one could not commit more violent acts of suicide; for this reason, it would be foolish to allow a subintentionally suicidal patient the opportunity to commit more violent suicide by shaving himself or allowing him to cut his own meat--at least for the first few weeks. For the same reason, a diabetic patient suspected of committing subintentional suicide should not be allowed to give his own insulin injections--at least until the danger of suicide diminishes. By establishing an environment free of temptations to commit violent suicide, a patient could be more amenable to methods of treatment and referral.
2. *Considering the possibility of a "Bereavement Overload."* If it could be concluded that the majority of nursing home suicides are egoistic, then the root of the suicide acts is a feeling of depression. The depression may be caused by drugs, a previous emotional state or even simple grief. In the case of a "bereavement overload", the patient experiences an excess amount of grief (i.e.: the patient is terminal, the patient is mourning the loss of others, the patient has recently lost a spouse or significant other, etc.) that could be considered a normal part of life. While the depression itself is a normal stage of emotional growth in the case of a "bereavement overload", the way the patient expresses the depression may indeed be psychopathological.
3. *Sensitizing oneself to the patient's needs.* Recent research has shown that elderly people who attempt suicide [in whatever manner] are sane and have made a reasonable decision based upon real circumstances. Thus, an elderly patient who attempts subintentional suicide is not crazy and should not be treated as such. The need of the patient is the support of the helping professional and the reassurance that the patient's life will be missed. If a patient is attempting subintentional suicide, then the helping professional has a responsibility to become concerned with the patient's needs; if the patient's de-

pression is caused by grief, even if it happened thirty years ago, one should not regard the patient as confused, disoriented or senile--the patient's need is not to be ignored, but to be received by others.

4. *Being honest and truthful.* A suicidal patient is in need of the helping professional's genuine help and concern; one should not promise anything that cannot be done. A patient who realizes that he has been patronized and deceived may very well be tempted to make further attempts at suicide: subintentional, violent or passive. Above all, a helping professional should try to convince the patient that he/she cares and could be confided, and not that he/she is "just like the rest of them."

Methods of Treatment and Referral for Subintentionally Suicidal People

Once suicidal tendencies are accurately detected, the job of the staff is to provide appropriate interventions. However, the success rate of elderly persons who attempt suicide is very high, the staff may have very few opportunities to render treatment to patients assessed to be suicidal. It is therefore imperative that the nursing staff be cognizant of various treatment methods and considerations as well as methods of avoiding conflicts while rendering treatment.

Kastenbaum and Mishara suggest the implementation of four treatment methods in caring for potentially suicidal elderly patients. One method they recommend is for the facility to *encourage continuity of care.* With this method, the same staff are used to provide care for the patient, and are not moved to other wards or shifts abruptly. While problems in turnover may make continuity of care difficult, care should be used in attempting to promote continuous care for patients who are subintentionally suicidal. The period of continuous care should be as long as it takes for the patient to become less of a danger to him- / herself. In extreme cases where an aide could not possibly handle the same shift for an extended period of time, the patient's family should be encouraged to hire a private duty nurse for the first week or so following detection.

A second method is to *prevent "Translocation Shock."* Translocation shock is a fear that the patient is being abandoned or that no one cares about the patient anymore; this fear could trigger more depression and renewed suicidal behaviors which would impede any kind of treatment or sense of well-being. Translocation

could also be triggered by transfer to an acute hospital for treatment; in nursing homes it is triggered by moving patients from room to room--whether to a different toom set aside for special patients or to an entirely different ward or building. In moving to an acute hospital, a dilemma is created of intending to treat physical problems at the risk of creating greater emotional problems. For example, if a patient is prescribed medications to treat the physical discomforts of stress and anxiety, the resulting depression from the drugs may invite further suicidal acts, which might, in turn, result in increased doses of those same medications.

A third method is to *foster "Interpersonal Mutuality"*. Interpersonal mutuality is little more than allowing the patient to make his/her own decisions and providing extra opportunities to allow the patient to act independently and responsibly. For example, the patient might be given the choice of waking up with the other patients for the first week or so or being allowed to sleep late; in such an event, breakfast trays could be ordered ahead of time to allow the patient to eat late. These additional choices are very necessary during the first week or so, especially when the patient is convinced that no one gives a damn about his/her needs and feelings. Such feelings of abandonment are usually temporary, but very real to the patient.

A fourth method suggested by Kastenbaum and Mishara is to *positively reinforce comfort-giving behaviors*. Anger and depression are not erased in two hours; moreover, it might be several months before the person returns to his old self. In the meantime, people may feel uncomfortable being around a kind of person who is always depressed or is screaming in rage at 2:00 a.m. It is entirely possible to transform a person from one who is a source of discomfort to others to one who is a source of comfort to others. This transformation is accomplished through sublimating rage and depression via socially acceptable means; the vehicle for this sublimation is through various resource persons usually within the nursing home environment. One resource person is the Activities Director who can utilize the fine arts as vehicles for emotional sublimation. Another resource person is the social worker who can be a useful link to community programs such as "foster grandparents" and R.S.V.P.; community service is a way to transform fears of abandonment into ways to help others avoid those same fears. (Kastenbaum and Mishara, 1971)

Butler and Lewis feel that the anger suicidal persons feel [especially the person who attempts "egoistic" suicide] should be confronted and expressed. Therapeutic interventions simply to draw out the anger the patient has inside of him/her is usually not enough; "anger can be a cover for deeper problems

that may be centered, for instance, around the need for intimacy and a profound sense of deprivation. These underlying problems must be brought out. Direct confrontation may be necessary" (Butler and Lewis, 1977).

Staff Considerations in Treating Subintentionally Suicidal Patients

Although there are many articles written that are pertinent to the treatment of suicidal persons, very little is written about suggestions that could be made to the staff who perform these interventions. Suicidal persons (especially elderly ones) have a tendency to bring out the worst in many people. Four reactions commonly observed among the nursing staff who attempt to treat the patient are anger, despair & depression, fear and guilt (Burnside, 1976).

One reaction is the *anger* that is evoked when it is assumed that the patient is committing suicide as a direct result of his/her non-appreciation of the good medical care provided. Moriwaki found that is is not uncommong for the patient to sense that good care was rendered; moreover, the nurse's fear that the patient is resentful of nursing care provided is fairly inaccurate when confronted with the evidence. Moriwaki reported that she "studied suicide behavior for psychological autopsies, and that elderly patients hanged themselves on the grounds away from their ward or had gone home on pass to complete the act" (Moriwaki, 1974).

Feelings of *despair and depression* are common among staff, where he/she considers old age and shudders at the thought of living in the particular facility. It should be emphasized to them that there is a 75% chance that they will never be a patient in a nursing home; furthermore, at any one time, 96% of all elderly people are not in institutions of any kind, but in the community and living very satisfying lives. There is, thus, a fairly slight chance that staff will face exactly the same dilemmas that their patients may be experiencing.

Feelings of *fear* that are evoked when one sees one's patient attempting to commit subintentional suicide are usually very intense; most facilities try to eliminate this reaction by denying that the patient is attempting to commit suicide altogether. To allay the fears staff experience when confronting suicidal people, frequent staff meetings, change-of-shift reports and in-service education seminars could be utilized on a regular basis. The use of in-service education to help staff deal more effectively with feelings aroused by suicide attempts, as well as by potentially suicidal patients in general was the topic

of a past research project by the author.

The feeling of *guilt* is an integral part of the grieving process; staff experience guilt when they realize that suicide attempts could have been avoided through proper detection and intervention. While the facility administration attempts to spare the staff from feelings of fear, it is ineffectual in dealing with the intense feelings of guilt that the staff members experience. The staff is rarely given the opportunity to discuss their feelings of guilt; hence, feelings of guilt are rarely resolved among nursing home staff.

Additional Remarks

While Durkheim noted that older people are more likely to commit suicide than younger people, he made little distinction between older people in the community and those in institutions. Suicidal institutionalized elderly are more prone to subintentional self-destructive maneuvers than suicidal community elderly. To detect these maneuvers, the staff must be specifically trained, counseled and encouraged. Since allowing suicides to be committed is not beneficial to other patients, the staff or the facility, appropriate interventions must be utilized with the suicidal patient. Before the staff can utilize interventions to benefit the patient, others must use interventions that benefit the staff. Only through teamwork and sincere efforts, can the staff minimize the effects of apathy, depression and hyperregulation that are so characteristic of many suicidal people. The problem of suicide among the elderly is best described by Carl Eisdorfer in his paper, "Controlled Environment For Old People:"

> "I wonder about the quality of life that drives such high proportions of our people into the most manifest self-destruction. What greater evidence of personal anguish can they give us?" (Eisdorfer, 1970).

The Suicide Awareness Scale (SAS)

INTRODUCTORY OBSERVATIONS

The assembly and redactions of the SAS into the finished product reflect the culmination of 1 1/2 years of intensive research. The questionnaire tests previous knowledge of sub-intentional suicidal tendencies that aides and orderlies in SNF's would have to acquire to make appropriate assessments and referrals. A dependent variable, staff helplessness, is hypothesized to occur when aides and orderlies are not attuned to sub-intentional suicidal behaviors that their patients exhibit, and thus feel helpless when they cannot make appropriate interventions. Questionnaires were sent to a small sample of In-Service education programs in the Los Angeles area, and the author is still awaiting responses from that sample. Upon receipt of all responses, appropriate statistics to test for sampling error and to perform factor analyses of the responses will be used. Until these statistical procedures are performed, the scale remains unstandardized yet an important research breakthrough nonetheless.

The scale is composed of 31 questions; six of them are non-scored, but are included to ensure spontaneity of responses to scored questions. The 25 scored questions are divided into four categories: staff helplessness [the primary dependent variable], sub-intentional suicide detection, supportive techniques for the self-destructive elderly and treatment/referral practices for self-destructive patients. The helplessness section is comprised of ten questions and refers to questions 2, 3, 5, 6, 8, 9, 11, 12, 13, 14. The suicide detection section is comprised of five questions and refers to questions 16 - 20. The supportive techniques section is comprised of five questions and refers to questions 21 - 25. The treatment/referral section is comprised of five questions and refers to questions 26 - 30. Finally, the non-scored section is comprised of six questions and refers to questions 1, 4, 7, 10, 15, 31.

Respondent information is solicited on the cover page to the SAS and such data will be used to categorize respondents statistically; no information is asked that could be used to identify the respondent at a later date to insure confidentiality. Directions are explicitly stated on the cover page and In-Service personnel are urged to take the extra time to ensure that staff are thoroughly informed of the manner in which to mark their responses. Respondents are asked in two separate places in the questionnaire to answer every question; from preliminary returns of the questionnaires, no missing values were found [which perhaps is related to the explicit instructions against leaving questions blank]. Finally, nowhere on the SAS is it stated that these questions measure suicide awareness to reduce anxiety on both the aide and managerial levels; furthermore, only 10% of scored questions even use the word "suicide" in the whole SAS. Further discussion about the scale will be found on page 23, or its equivalent.

THE STAFF AWARENESS SCALE (S.A.S.)
Devised By: David I. Samuels

Directions:

On the next 6 pages, you will see 31 statements, and a series of phrases following each statement. The phrases are these:

"Very Strongly Disagree"

"Strongly Disagree"

"Disagree"

"Agree"

"Strongly Agree"

"Very Strongly Agree"

Here is an example of how to answer a sample question:

I have a wart on my nose that makes me feel ugly.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

If you have a beautiful nose that is totally free of warts, you would not feel ugly, and would therefore mark an "X" in the space above the phrase "Very Strongly Disagree" like this:

X
Very Strongly Disagree

If you had a wart the size of a baseball on your nose, and if you felt very ugly as a result, then you would probably mark an "X" in the space above the phrase "Very Strongly Agree." If you had a wart on your nose that makes you feel like one of the crowd, but not ugly, then you would probably mark an "X" above the phrase "Disagree" while if you had a mole on your nose that makes you feel ugly then you would probably mark an "X" above the phrase "Agree."

General Information:

Length of Employment: _____ Months, _____ Years. Sex: ___ Male / ___ Female

Status: ___ Never Married / ___ Married / ___ Single / ___ Widowed. Age: _____

Shift: ___ A.M. / ___ P.M. / ___ NOC. Classification: ___ Part-Time / ___ Full-Time

Introduction:

The S.A.S. Scale is an experimental questionnaire in the area of Death and Dying. All information and answers will be kept strictly *confidential; no response will be shown to your supervisors.* Please try to relax, and answer each question honestly. Remember, you are to respond as to the extent you disagree or agree with each statement given. Please take as much time as you need; when you are finished please give this questionnaire back to your instructor. Thank you.

THE S.A.S. SCALE (Page 1)

1. Many aides are still here after 6 months.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

2. Some of my patients get into the freakiest accidents, but there's really nothing I can do about those things.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

3. You have to be thick-skinned to stay working here; I've seen things that would make a thin-skinned aide quit in an instant.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

4. If I had a dime for every time someone said to me, "You could never get me into one of those awful nursing homes!" I'd have more money than the president of General Motors.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

5. There is really nothing I can do when I see a patient who's been so strong go downhill so quickly.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

6. There are so many patients here that it's too hard to remember how each of them acts from day to day.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

PLEASE CONTINUE THE QUESTIONNAIRE
ON THE NEXT PAGE

7. My salary won't make me a millionnaire, but my work is very rewarding.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

8. Most of these people can't think independently enough to commit suicide.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

9. I can't understand why anyone would refuse his medications.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

10. Even if I were offered a little more pay to work with a wide range of people in a hospital, I would not change jobs because I get more satisfaction working just with older people.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

11. I feel helpless when I see someone dying because I can't do anything to help him.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

12. It's too hard to figure out which patients are really depressed; some of the drugs they take make it pretty hard to tell.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

PLEASE CONTINUE THE QUESTIONNAIRE ON THE NEXT PAGE

13. The better the nursing care I give my patients, the longer they'll live.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

14. I would like to be trained in cardiopulmonary rescusitation and other emergency methods to make me a more effective nurse's aide here. [*If you are already trained in cardiopulmonary rescusitation, please skip this question.*]

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

14a. My training in cardiopulmonary rescusitation (C.P.R.) and other emergency methods would come in very handy in a crisis here. [*If you are NOT trained in C.P.R., please skip this question.*]

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

15. Skilled nursing care is very hard work, but the satisfaction of working with the elderly is well worth the effort.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

16. The aide who lets a patient go out in the cold without a sweater or jacket on should be the one who's blamed in case something happens.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

17. No patient could commit suicide here; all dangerous things are kept well out of the patient's reach.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

18. I'd never think twice if a hearty eater suddenly stopped eating for awhile; I sometimes get like that, too.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

19. I've rarely seen anyone die here because any patient who's that close to death is usually moved to an acute facility.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

20. There is no real excuse for a patient not taking his medications when they are given out.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

21. It's much too difficult for me to be around uncooperative patients for any length of time.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

22. It does more harm than good for an aide to ever "baby" a patient.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

23. Our turnover is so low that patients get to know an aide very well before he leaves.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

24. My workload is light enough that I can give the patients the kind of care that they really deserve.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

PLEASE CONTINUE THE QUESTIONNAIRE ON THE NEXT PAGE

25. It's a good idea to set aside special rooms for those patients who are dying.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

26. I am encouraged to chart emotional as well as physical changes in my patients.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

27. I am encouraged to do as much as possible by myself; only if there is something I really cannot do, should I consult my charge nurse.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

28. If there's a social worker here, I'm not sure exactly what that person does.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

29. I'm not supposed to deal with patients who've tried to commit suicide, because someone like that is mentally ill and should be locked up.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

30. A good nurse's aide should be concerned only with the course of each patient's physical health and leave mental health matters to the experts.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

PLEASE CONTINUE THE QUESTIONNAIRE ON THE NEXT PAGE

31. There is no good, rational reason for committing suicide; teenage suicide is bad enough, but suicide among the elderly is something I really don't understand.

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree

Thank you for answering each question carefully and honestly. Please check to make sure that you have answered each question and have marked only one of the answers. *When you are finished, please hand in this questionnaire to your instructor.*

CONCLUDING DISCUSSIONS

The SAS is far from conclusive about the problems that geriatric SNF suicides pose to health care professionals. Further research is necessary to determine if helplessness as a variable is positively correlated to staff turnover or to job dissatisfaction at the very least. Statistical measures have to be applied to determine if this scale is even a valid measure of the variables being analyzed. A larger sample should be solicited simply to standardize this scale for more generalized use among health care professionals who want to better the lives of their potentially self-destructive elderly patients. The need is clear; the means toward achieving the goal of promoting well-being upon potentially self-destructive patients has only now truly begun.

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